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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was sent electronically on 11/08/22. A revised 2567 was sent electronically on 12/14/22.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/08/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 43 residents. Based on observation, record review, and interviews, the facility failed to promote a dignified dining experience during meal service for Resident (R)17, R26, and R28. This deficient practice placed the residents at risk for impaired dignity and decreased psychosocial well-being.

Findings Included:

- On 10/25/22 at 11:55AM R28 attempted to eat his meal in the dining room. R28 sat across from R26 (severely physically and cognitively impaired resident). R26 struggled to eat his meal and began coughing. R26 was unable to cover his mouth due to his physical impairment and coughed in the direction of R26's plate and drink. Staff did not intervene or help R26 during this time. At 12:05PM R28 requested to be moved to a different table and stated, "I can't enjoy my meal with him coughing all over my food"." R28 was moved to a different table close to the window.

On 10/25/22 at 12:15PM R17 was transported into the dining room for his lunch in his Broda

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Chair (specialized wheelchair with the ability to tilt and recline). While being transported to his table, an unidentified staff member requested that R28 be moved "out of the way" so staff could bring in "the feeder." Staff referred to R17 as the feeder in reference to him needing total assistance for his meals. R28 was moved again to allow R17 access to the rear table by the window. R28 was not offered a new plate of food or to have his food warm during/after the incident.

On 10/27/22 at 01:30PM in an interview, Certified Nurses Aid (CNA) M, stated each resident has the right to be treated with respect and dignity. He stated that staff would never refer to resident with nicknames and should call them by their preferred names.

On 10/27/22 at 03:03PM in an interview, Administrative Nurse D stated that all residents should be treated with dignity and respect. She stated that staff should never use the term "feeder" to identify a resident. She stated that staff should always call the residents by their preferred names and ask permission before moving them.

A review of the facility's "Resident's Right and Responsibilities" revised 06/2021 stated that each resident had the right to be treated with dignity, consideration, courtesy, and respect with full recognition of their individuality.

The facility failed to promote a dignified dining experience during meal service for R17, R26, and R28. This deficient practice placed the residents at risk for impaired dignity and decreased psychosocial well-being.

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F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)	F 676		

§483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:

§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...

§483.24(b) Activities of daily living.
The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:

§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,

§483.24(b)(2) Mobility-transfer and ambulation, including walking,

§483.24(b)(3) Elimination-toileting,

§483.24(b)(4) Dining-eating, including meals and snacks,

§483.24(b)(5) Communication, including
(i) Speech,
(ii) Language,

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(iii) Other functional communication systems.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 43 residents. The sample included 12 residents with five reviewed for activities of daily living (ADL's). Based on observation, record review, and interviews, the facility failed to provide Resident (R)26's assistance with eating to prevent aspiration (inhaling liquid or food into the lungs) during his meals. This deficient practice placed him at risk for aspiration and related complications.

Findings Included:

-The "Medical Diagnosis" section within R26's Electronic Medical Records (EMR) included diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dysphagia (swallowing difficulty), chronic kidney disease, gastro-esophageal reflux disease (GERD-progressive mental deterioration characterized by confusion and memory failure), and history of unspecified pneumonia (inflammation of the lungs).

A review of R26's "Significant Change Minimum Data Set (MDS)" dated 10/12/22 revealed a Brief Interview for Mental Status (BIMS) score of three indicating severe cognitive impairment. The MDS indicated that he weighed 181 pounds (lbs.) with no weight loss and received a mechanically altered diet. He required supervision, oversight,

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encouragement and cueing with one person physical assistance with eating.

A review of R26's "Nutrition Care Area Assessment (CAA)" dated 10/22/22 indicated that he was a risk related to his cognitive loss, medical diagnoses, and reduced vision. The CAA noted that he required a mechanically soft diet.

R26's "Care Plan" revised 10/16/22 indicated that he was at risk for aspiration and pocketing food while consuming his meals. The plan noted that he would experience a loss of food and liquids, coughing, and choking during meals and medications administration. The plan instructed staff to encourage him to consume his meals. The plan noted he was to eat his meals in the dining room. The plan noted that staff would cue R26 to alternate his food and drink per speech therapy recommendations. The plan instructed staff to provide nectar thick liquids to drink.

A review of R26's "Physician's Orders" indicated that he admitted to the facility on 03/09/21 with a mechanically soft diet with ground meats. R26 received a new dietary order on 09/02/22 for him to start a pureed diet with nectar thick liquids.

A review of R26's "Functional Maintenance Plan" dated 09/06/22 indicated recommendations from the speech therapist that staff were to encourage small bites and sips, offer drinks every two to three bites, and encourage R26 to eat slowly.

On 10/25/22 at 09:13AM R26 was in the dining room for breakfast. R26 sat in his Boda Chair (specialized wheelchair with the ability to tilt and recline) in the main dining room. He had his pureed meal served to him on a divided plate with

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a side guard to prevent spillage. R26 was served a bright red drink of thin liquid consistency. He then picked up his weighted spoon and scooped up a large spoonful of his pureed meal. He ate the spoonful and continued to consume his meal with spoonful sized bites of his meal. R26 then consumed his liquid thin drink without sipping or taking small drinks. Staff were observed assisting other residents during meal service but not supervising R26's meal or fluid consumption. At 09:36 R26 began coughing. He sat in the dining room coughing for ten minutes before staff moved him to his room to recover.

On 10/25/22 at 11:55AM R26 sat in the dining room and ate his lunch without staff assistance. R26 scooped spoonful-size bites of his pureed beef and swallowed it. He began coughing loudly. He drank some of his thin liquid juice and continued to struggle with coughing. Staff did not intervene with assisting him until 12:05PM. Staff did not cue him to takes small bites and sips until he began to cough.

R26 continued to have repeated coughing and aspiration observations during both breakfast and lunch meal services for 10/26, and 10/27 with staff not supervising him during meal consumption.

On 10/27/22 at 01:30PM in an interview with Certified Nurses Aid (CNA) M, he stated that R26 was supposed to be on a pureed diet with nectar thick liquids per his physician orders. He stated that the CNA staff were responsible for preparing drinks and assisting with all the resident's meals. He stated that each resident's dietary requirements were listed in the "Care Plans" and on a dietary sheet at the dining room. He stated

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F 676	Continued From page 7 that staff were to encourage R26 to eat his meals slowly. He stated that staff were to watch him for signs of choking and encourage him to take small bite and sips from his drink. On 10/27/22 at 01:50PM in an interview with Licensed Nurse (LN) G, she stated that the direct care staff assist the residents with meals and drinks. She stated that R26 required a pureed diet and nectar thick liquids to drink. She stated that staff were to ensure that he was sitting upright and to encourage R26 to eat slowly with small bites and sips from his drink. A review of the facility's "Rehabilitative Services" policy revised 06/2021 indicated that the therapy departments will work with community nurses to develop effective restorative nursing programs for residents including physical therapy, occupational therapy, and speech-language therapy. The policy noted that treatment programs were planned based on the findings and recommendations of the therapist. The facility failed to provide R26 the required assistance with eating to prevent aspiration during his meals. This deficient practice placed him at risk for aspiration and related complications.	F 676		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		

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supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 43 residents. The sample included 12 residents with four residents reviewed for accidents. Based on observation, record review, and interviews, the facility failed to follow Resident (R) 24's plan of care which directed extensive assistance of two staff members for transfers. This placed R24, who had a history of falls, at increased risk for accidents and potential major injuries related to falls.

Findings included:

- R24's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), instability right knee and repeated falls.

The "Significant Change Minimum Data Set" (MDS) dated 09/12/22 documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented that R24 required extensive assistance of two staff members for activities of daily living (ADLs). The MDS documented R24 had one fall with major injury (bone fracture, joint dislocations, closed head injury with altered consciousness, subdural hematoma) during the look back period.

R24's "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 09/15/22 documented R24 required extensive

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assistance with toileting transfers.

R24's "Care Plan" dated 03/07/22 documented R24 was lowered to the floor in the bathroom. Staff were educated on R24's care planned transfer status.

The "Functional Management Program" sheet dated 03/01/22 located in the care plan book stored in R24's closet, documented for transfers the sit to stand lift was to be used.

Review of the "Nurse Notes" documented on 03/07/22 at 04:22 PM R24 was on the toilet when Certified Nurse's Aide (CNA) O attempted to transfer R24 by turn and pivot. Due to miscommunication from the (unidentified) Licensed Nurse (LN) on R24's transfer status, R24 lost footing when attempting to transfer back to the wheelchair and was lowered to the floor by the CNA.

Review of the "Fall Investigation" dated 03/07/22 documented CNA O was the only witness to the fall.

On 10/26/22 at 02:02 PM R24 sat in the wheelchair in the common area outside her room, no behaviors or distress noted. noted.

On 10/27/22 at 01:45 PM CNA N stated the staff know how and how much assistance each resident required for transfer could be found in the care plan book located in each resident's closet or in the EMR. CNA N stated R24 was transferred with two people and the sit to stand lift.

On 10/27/22 at 02:20 PM LN H stated after a

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F 689	Continued From page 10 resident fell, she notified the director of nursing and or the assistant director of nursing of the fall. LN H stated they discussed an intervention to care plan to prevent further falls. LN H stated the mode of transfer and the assistance needed for each resident was found in the care plan cook in the resident's closet. On 10/27/22 at 03:05 PM Administrative Nurse D stated education would be provided to staff when an incorrect transfer had occurred that resulted in a fall. The facility "Fall Management" policy last revised May 2021 documented to minimize and/or decrease the risk of falls was through an interdisciplinary review of resident and develop an individualized care/service approach. Completing a Holistic Assessment Care Plan) to ensure fall risk section was accurately reflected the resident. The facility failed to follow the care plan for transfers for R24, which placed her at risk of major injury from falls.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must	F 690		

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ensure that-
(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 43 residents. The sample included 12 residents with two reviewed for bowel and bladder incontinence. Based on observation, record review, and interviews, the facility failed to establish an individualized bowel and bladder programs for Resident (R)16 and R34. This deficient practice placed the residents at risk for complications related to incontinence and increased incontinence.

Findings Included:

-The "Medical Diagnosis" section within R16's

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Electronic Medical Records (EMR) included diagnoses of major depressive disorder (major mood disorder), moderate weakness, epilepsy (brain disorder characterized by repeated seizures), chronic pain syndrome, lack of coordination, overactive bladder, and arthritis (inflammation of a joint characterized by pain, swelling, heat, redness and limitation of movement).

A review of R16's "Quarterly Minimum Data Set (MDS)" dated 08/26/22 revealed a Brief Interview for Mental Status (BIMS) score 15 indicating no cognitive impairment. The MDS indicated that she was occasionally incontinent of urine and frequently incontinent of bowel. The MDS noted that a toileting program had not been attempted.

R16's "Urinary Incontinence Care Area Assessment (CAA)" dated (03/11/22) revealed that she required extensive assistance for all activities for daily livings (ADL's). The CAA noted that she was occasionally incontinent of urine.

A review of R16's "Care Plan" revised 08/26/22 indicated that R16 required extensive one-person physical assistance for toileting. The plan noted that R16 must use a slide board for transfers and a bedpan for toileting due to her recent shoulder surgery. The plan stated that staff were to check on her routinely for incontinence. The plan noted that R16 was always continent of bowel. The plan noted that R16 was at potential risk for infections and skin breakdown related to her incontinence.

R16's clinical record lacked evidence the facility assessed voiding/elimination patterns, and lacked evidence ressident centered interventions were

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identified and implemented in an effort to decrease incontinent episodes.

On 10/25/22 at 11:35AM R16 reported that the facility attempted to do their best with assisting her with her ADLs but sometimes were a little slow. She stated that she has had many episodes of both bowel and bladder incontinence related to staff not answering the call light on time or even checking in on her. R16 stated that she was not on a toileting program and was not sure if a trial program was attempted since her admission. She stated that she used to complete her toileting by herself before she was admitted but required assistance now due to her decline in health.

On 10/27/22 at 01:30PM in an interview, Certified Nurses Aid (CNA) M, stated that all the resident were checked on every two hours for restroom breaks and incontinence. He stated that R16 was not on a specified toileting plan or program but R16 could alert staff when she needed to use the restroom. He stated that R16 was incontinent and does have periodic episodes of both bowel and bladder incontinence.

On 10/27/22 at 01:50PM in an interview, Licensed Nurse (LN) G stated that R16 was not on a toileting program and was not sure if a voiding trail had been completed since her admission. She stated that R16 was able to notify staff when she needed a restroom break and if she needed assistance with incontinence cares.

On 10/27/22 at 03:03PM in an interview, Administrative Nurse D stated that R16 was aware enough of her bathroom needs to alert staff when she needed to use the restroom. She stated that the facility did not complete a specific

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bowel or bladder assessment or establish incontinence patterns, but rather used information provided by the resident upon admission to determine the residents needs for incontinence. She stated that the facility also talked with each resident about there specific needs to add interventions for care.

On 10/27/22 at 03:10PM Administrative Nurse D stated that the facility did not have a policy for "Bowel and Bladder Incontinence Management".

The facility failed to establish an individualized bowel and bladder toileting program for R16. This deficient practice placed the resident at risk for complications related to incontinence and for impaired dignity related to increased incontinence.
- R34's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of mixed incontinence (stress incontinence: the unintentional loss of urine) and urge incontinence (involuntary passage of urine occurring soon after a strong sense of urgency to void) symptoms at the same time.

The "Annual Minimum Data Set" (MDS) dated 09/28/22 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented that R34 required limited assistance for activities of daily living (ADLs). The MDS documented R34 was not on a toileting program and was frequently incontinent of bladder (seven episodes of urinary incontinence and at least one episode of continence) during the look back period.

R34's "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated

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10/09/22 documented R34 was continent of bowel and had occasional bladder incontinence, related to mixed incontinence.

R34's "Care Plan" dated 01/13/22 documented staff were to offer toileting upon rising, before and after meals, at bedtime and as needed.

R34's clinical record lacked evidence a bladder retraining program was attempted or implemented.

On 10/25/22 at 10:54 AM R34 sat the wheelchair next to the bed. He stated he had an incontinent episode that morning. R34 stated he did not make it in time for the bathroom.

On 10/27/22 at 01:45 PM Certified Nurses Aide (CNA) N stated she was not aware of any residents that had an individualized toileting plan or any type of bowel or bladder assessment. CNA N stated R34 was incontinent of his bladder at times and every one that was incontinent was helped with toileting upon rising, before and after meals, at bedtime and after incontinent episodes.

On 10/27/22 at 02:20 PM Licensed Nurse (LN) H stated the facility had a bowel and bladder assessment that was completed in the past at the time of admission, but that assessment was no longer in use. LN H stated she was not aware of any resident that was on an individualized toileting plan or bladder retraining program.

On 10/27/22 at 02:40 PM Administrative Nurse E stated the facility did not complete a true bowel and bladder assessment for the residents at the time of admission. Administrative Nurse E stated the facility completed a holistic collaborative plan

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F 690	Continued From page 16 (care plan) of toileting the residents every two hours. On 10/27/22 at 03:05 PM Administrative Nurse D stated the facility did not complete any type of monitoring of voiding patterns for the residents upon admission. Administrative Nurse D stated the facility received report from the discharging facility concerning the resident's continence, and the facility offered every two-hour voiding until the facility determined the residents' routines. The facility was unable to provide a policy related to bowel and bladder assessments. The facility failed to provide an individualized toileting program and/or bladder retraining for R34 to promote continence and maintain dignity and well-being.	F 690		
F 807 SS=D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: The facility identified a census of 43 residents. The sample included 12 residents with five reviewed for specialized diets. Based on observation, record review, and interviews, the facility failed to provide Resident (R) 26's physician ordered nectar thick liquids during meal service. This deficient practice placed him at risk	F 807		

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for complications related to aspiration (inhaling liquid or food into the lungs) .

Findings Included:

- The "Medical Diagnosis" section within R26's Electronic Medical Records (EMR) included diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dysphagia (swallowing difficulty), chronic kidney disease, gastro-esophageal reflux disease (GERD-progressive mental deterioration characterized by confusion and memory failure), and history of unspecified pneumonia (inflammation of the lungs).

A review of R26's "Significant Change Minimum Data Set (MDS)" dated 10/12/22 revealed a Brief Interview for Mental Status (BIMS) score of three indicating severe cognitive impairment. The MDS indicated that indicated that he weighed 181 pounds (lbs.) with no weight loss indicated and a mechanically altered diet.

A review of R26's "Nutrition Care Area Assessment (CAA)" dated 10/22/22 indicated that he was a risk related to his cognitive loss, medical diagnoses, and reduced vision. The CAA noted that he required a mechanically soft diet.

R26's "Care Plan" revised 10/16/22 indicated that he was at risk for aspiration and pocketing food while consuming his meals. The plan noted that he would experience a loss of food and liquids,

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coughing, and choking during meals and medications administration. The plan instructed staff to encourage him to consume his meals. The plan noted he was to eat his meals in the dining room. The plan noted that staff would cue R26 to alternate his food and drink per speech therapy recommendations. The plan instructed staff to provide nectar thick liquids to drink and a puree diet
.
A review of R26's "Physician's Orders" indicated a dietary order on 09/02/22 for a pureed diet with nectar thick liquids.

On 10/25/22 at 09:13AM R26 was in the dining room for breakfast. R26 sat in his Boda Chair (specialized wheelchair with the ability to tilt and recline) in the main dining room. He had his pureed meal served to him on a divided plate with a side guard to prevent spillage. R26 was served a bright red drink of thin liquid consistency. He then picked up his weighted spoon and scooped up a large spoonful of his pureed meal. He ate the spoonful and continued to consume his meal with spoonful sized bites of his meal. R26 then consumed his liquid thin drink without sipping or taking small drinks. At 09:36AM R26 began coughing. He sat in the dining room coughing for ten minutes before staff moved him to his room to recover. He continued to cough in his room until 09:44AM.

On 10/25/22 at 11:05PM R26 was observed drinking thin liquid juice for lunch. R26 continued to struggle with coughing. R26 took several drinks from his juice. Staff intervened at 12:09PM to cue him to slow down and take smaller bites. R26's coughing improved with staff's assistance.

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An observation of R26's drinks for his breakfast and lunch for 10/26 and 10/27 revealed he had the correct nectar thick consistency drinks.

On 10/27/22 at 01:30PM in an interview with Certified Nurses Aid (CNA) M, he stated that R26 was supposed to be on a pureed diet with nectar thick liquids per his physician orders. He stated that the CNA staff were responsible for preparing drinks and assisting with all the resident's meals. He stated that each resident's dietary requirements were listed in the "Care Plans" and on a dietary sheet at the dining room. He stated that staff were to encourage R26 to eat his meals slowly. He stated that staff were to watch him for signs of choking and encourage him to take small bite and sips from his drink.

On 10/27/22 at 01:50PM in an interview with Licensed Nurse (LN) G, she stated that the direct care staff assist the residents with meals and drinks. She stated that R26 required a pureed diet and nectar thick liquids to drink. She stated that staff were to ensure that he was sitting upright and to encourage R26 to eat slowly with small bites and sips from his drink.

A review of the facility's "Interpretation of Diet Orders" policy revised 01/2020 indicated that specialized diets would be provided based upon the resident's and preferences. Staff will follow the dietary orders as they are written and will consult with the dietician if needed for changes to the orders.

The facility failed to provide R26's physician ordered nectar thick liquids during meal service. This deficient practice placed him at risk for complications related to aspiration.

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F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 43 residents. The sample included 12 residents. Based on observation, record review and interview, the facility failed to ensure staff followed infection control standards of practice. The facility failed to appropriately store/cover residents' clean laundry. The facility failed to properly store the scoop for an ice machine in a sanitary manner. This placed the residents at risk for increased infection and transmission of communicable disease.

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Findings included:

- An observation on 10/25/22 at 07:18 AM revealed multiple uncovered laundry baskets of clean residents clothing sat on the floor outside of the resident rooms (rooms 116, 117, 126,128, 129. 130, 133, 142, and 144).

An observation on 10/25/22 at 07:41 AM revealed a community ice machine scoop rested directly on a shelf with no barrier present and no cover.

On 10/27/22 at 2:00 PM Certified Nurse Aide (CNA) M stated that the clean laundry was transported uncovered in each resident's basket.

On 10/27/22 at 02:37 PM Administrative Nurse E stated the ice scoop should have had a barrier to be stored in and not on top of a shelf. Administrative Nurse E stated the current facility policy was that evening shift was to pull the dirty laundry from the resident's rooms and the night shift staff washed and folded the clean clothes and placed in the resident's laundry basket. The night shift staff would then place the clean laundry basket on the floor directly outside of the resident's door until the resident woke and the basket could be brought into the room.

On 10/27/22 at 03:05 PM Administrative Nurse D stated the ice scoop that was by the ice machine should not have been lying on a shelf. Administrative Nurse D said the clean laundry baskets were placed on the floor outside of resident rooms after they had been laundered during the night. Administrative Nurse D did not believe that the baskets were ever covered during transport around the facility.

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F 880	Continued From page 23 The facility "Laundry Policy for House Linens and Personal Laundry at Continuing Care" dated 11/01/14 documented personal laundry would be cleaned following a published schedule that would provide the residents with and adequate supply of clean personal clothing. Clothing would be picked up from rooms according to schedule and items logged. The cart containing soiled items must be covered during transport. Clean clothing would be returned to the resident's room as soon as possible according to the planned schedule. (The policy documented that clean linen carts must be clean and covered when delivering linen to storage closets on the floor but lacked direction of clean clothing transport). The facility failed to ensure the ice scoop was stored in a sanitary manner and failed to ensure clean linens and clothes were transported and stored in a sanitary manner. These deficient practices left the facility's residents vulnerable for the potential spread of infection and disease to all residents of the facility.	F 880		